# **ANTLER study Baseline**

Patient Study ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender male / female

Researcher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We are interested in finding out about **YOU** and **YOUR** experiences.

The following pages ask you a range of questions about your health and well-being, your feelings and your emotions. Unless otherwise stated, please choose only **ONE** response from the options available.

We understand that it is not always easy to choose an option that describes exactly what you are feeling, and if you are unsure of which response to give, please choose the response that comes closest to how you feel.

Please answer all the questions, there are no right or wrong answers.

**Please enter today’s date  /  / 20**

# **YOUR MOOD**

For each question please give the answer that comes closest to the way you have been feeling. (Please tick one box for each question).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the **last 2 weeks**, how often have you been bothered by the following problems? | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed or hopeless? | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much? | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy? | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating? | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself – or that you are a failure or have let yourself or your family down? | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television? | 0 | 1 | 2 | 3 |
| 1. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual? | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead, or of hurting yourself in some way? | 0 | 1 | 2 | 3 |

1. Compared to **2 weeks ago** how have your moods & feelings changed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **I feel a lot better** | **I feel slightly better** | **I feel about the same** | **I feel slightly worse** | **I feel a lot worse** |
| 1 | 2 | 3 | 4 | 5 |

1. Please describe any things that have changed? ............................................................................................................................................................................................................................................................................................................................................................................................................................................................

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| 1. In the past 3 months have you hurt yourself on purpose in any way (e.g. by taking an overdose of pills, or by cutting yourself)? | 1 | 0 |
| 1. If yes, on any of the occasions have you hurt yourself on purpose, have you ever seriously wanted to kill yourself? | 1 | 0 |

# **YOUR FEELINGS OF ANXIETY**

For each question please give the answer that comes closest to the way you have been feeling. (Please tick one box for each question).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the **last 2 weeks**, how often have you been bothered by the following problems? | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 1. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 1. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 1. Trouble relaxing | 0 | 1 | 2 | 3 |
| 1. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 1. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 1. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

|  |  |  |
| --- | --- | --- |
| This section asks about any feelings of anxiety/panic that you may have experienced **during the last 4 weeks**. | **Yes** | **No** |
| 1. In the **last 4 weeks**, have you had an anxiety attack – suddenly feeling fear or panic? | 1 | 0 |
| If “**Yes**” answer the questions below | | |
| 1. Has this ever happened before? | 1 | 0 |
| 1. Do some of the attacks come suddenly out of the blue – that is, in situations where you don’t expect to be nervous or uncomfortable? | 1 | 0 |
| 1. Do these attacks bother you a lot or are you worried about having another attack? | 1 | 0 |
| 1. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach? | 1 | 0 |

# **YOUR HEALTH AND WELL BEING**

For each question please give the answer that comes closest to the way you have been feeling. (Please tick one box for each question).

1. **In general**, would you say your health is

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Excellent** | **Very good** | **Good** | **Fair** | **Poor** |
| 1 | 2 | 3 | 4 | 5 |

The following questions are about activities you might do during **a typical day**. Does your health now limit you in these activities? If so, how much?

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes, limited a lot** | **Yes, limited a little** | **No, not limited at all** |
| 1. **Moderate activities**, such as moving a table, pushing a vacuum, bowling or playing golf | 1 | 2 | 3 |
| 1. Climbing **several** flights of stairs | 1 | 2 | 3 |
| 1. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports | 1 | 2 | 3 |
| 1. Bathing or dressing yourself | 1 | 2 | 3 |

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **All of the time** | **Most of the time** | **Some of the time** | **A little of the time** | **None of the time** |
| 1. **Managed to do less** than you would like | 1 | 2 | 3 | 4 | 5 |
| 1. Were limited in the **kind** of work or other activities | 1 | 2 | 3 | 4 | 5 |

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **All of the time** | **Most of the time** | **Some of the time** | **A little of the time** | **None of the time** |
| 1. **Managed to do less** than you would like | 1 | 2 | 3 | 4 | 5 |
| 1. Didn’t do work or other activities as **carefully** as usual | 1 | 2 | 3 | 4 | 5 |

1. How much **bodily** pain have you had during the **past 4 weeks**?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **None** | **Very Mild** | **Mild** | **Moderate** | **Severe** | **Very Severe** |
| 1 | 2 | 3 | 4 | 5 | 6 |

1. During the **past 4 weeks** how much did pain interfere with your normal work (including work both outside the home and housework)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Not at all** | **A little bit** | **Moderately** | **Quite a bit** | **Extremely** |
| 1 | 2 | 3 | 4 | 5 |

These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give one answer that comes closest to the way you have been feeling.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How much time during **the past 4 weeks** | **All of the time** | **Most of the time** | **Some of the time** | **A little of the time** | **None of the time** |
| 1. Have you felt calm and peaceful? | 1 | 2 | 3 | 4 | 5 |
| 1. Did you have a lot of energy? | 1 | 2 | 3 | 4 | 5 |
| 1. Have you felt downhearted and low? | 1 | 2 | 3 | 4 | 5 |
| 1. Have you been a very nervous person? | 1 | 2 | 3 | 4 | 5 |

16. During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives etc)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **All of the time** | **Most of the time** | **Some of the time** | **A little of the time** | **None of the time** |
| 1 | 2 | 3 | 4 | 5 |

# **YOUR HEALTH TODAY**

We would like to ask you about how your health is **today**. For each of the five questions below please indicate which statement best describes your own health state **today**. (Please tick **one** box for each question).

|  |  |  |
| --- | --- | --- |
| 1. Mobility | I have no problems in walking about | 0 |
|  | I have slight problems in walking about | 1 |
|  | I have moderate problems in walking about | 2 |
|  | I have severe problems in walking about | 3 |
|  | I am unable to walk about | 4 |
|  |  |  |
| 2. Self-Care | I have no problems washing or dressing myself | 0 |
|  | I have slight problems washing or dressing myself | 1 |
|  | I have moderate problems washing or dressing myself | 2 |
|  | I have severe problems washing or dressing myself | 3 |
|  | I am unable to wash or dress myself | 4 |
|  |  |  |
| 1. Usual Activities (e.g. work, study, housework, family or leisure activities) | I have no problems doing usual activities | 0 |
| I have slight problems doing my usual activities | 1 |
| I have moderate problems doing my usual activities | 2 |
| I have severe problems doing my usual activities | 3 |
| I am unable to do my usual activities | 4 |
|  |  |  |
| 1. Pain/Discomfort | I have no pain or discomfort | 0 |
|  | I have slight pain or discomfort | 1 |
|  | I have moderate pain or discomfort | 2 |
|  | I have severe pain or discomfort | 3 |
|  | I have extreme pain or discomfort | 4 |
|  |  |  |
| 1. Anxiety/Depression | I am not anxious or depressed | 0 |
|  | I am slightly anxious or depressed | 1 |
|  | I am moderately anxious or depressed | 2 |
|  | I am severely anxious or depressed | 3 |
|  | I am extremely anxious or depressed | 4 |
|  |  |  |

**YOUR MEDICATION**

We know it is sometimes difficult to remember to take medicines and that people sometimes miss doses, or even stop taking their tablets. We are interested in knowing about your experiences of taking your current antidepressant medication.

|  |  |  |
| --- | --- | --- |
| **Whilst you have been taking your medication…** | **Yes** | **No** |
| 1. Do you ever forget to take your medicine? | 1 | 0 |
| 1. Are you careless at times about taking your medicine? | 1 | 0 |
| 1. When you feel better do you sometimes stop taking your medicine? | 1 | 0 |
| 1. Sometimes if you feel worse when you take the medicine, do you stop taking it? | 1 | 0 |
| If you have answered **‘Yes’** to any of the questions above (1-4 , please answer **question 5**  below. | | |
| 1. Did you miss 2 or more days of your medication in a row? | 1 | 0 |

|  |  |  |
| --- | --- | --- |
| **Other Medication** | **Yes** | **No** |
| 1. Are you currently taking any other anti-anxiety, sleeping medication, including complementary/alternative medications (e.g. St John’s Wort)? | 1 | 0 |
| 1. If ‘**Yes’** please list medications   ............................................................................................................................................................................................................................................................................................................................................................................................................................................................................................  ..............................................................................................................................................................  ..............................................................................................................................................................  .............................................................................................................................................................. | | |

# **YOUR PHYSICAL SYMPTOMS**

The following questions ask you about symptoms you may have experienced **during the past 2 weeks**. Please tick only **one** answer for each question to indicate how often you have experienced these symptoms and also indicate whether you think these are caused by the antidepressant medication.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** | **IF SYMPTOM PRESENT: Do you think this is caused by the antidepressant medication?** | |
| 1. Back pain | 1 | 2 | 3 | 4 | YES | NO |
| 2. Stiffness in your arms or legs | 1 | 2 | 3 | 4 | YES | NO |
| 3. Headaches | 1 | 2 | 3 | 4 | YES | NO |
| 4. A rapid heart beat | 1 | 2 | 3 | 4 | YES | NO |
| 5. Agitation | 1 | 2 | 3 | 4 | YES | NO |
| 6. Dry mouth | 1 | 2 | 3 | 4 | YES | NO |
| 7. Excessive sweating | 1 | 2 | 3 | 4 | YES | NO |
| 8. Stomach pains | 1 | 2 | 3 | 4 | YES | NO |
| 9. Felt sick or nauseous | 1 | 2 | 3 | 4 | YES | NO |
| 10. Daytime drowsiness | 1 | 2 | 3 | 4 | YES | NO |
| 11. Light headedness or dizziness | 1 | 2 | 3 | 4 | YES | NO |
| 1. Hot flushes | 1 | 2 | 3 | 4 | YES | NO |
| 1. Difficulty sleeping | 1 | 2 | 3 | 4 | YES | NO |

If you have experienced any of the following symptoms in the **previous 3 months** please tell us if they are new or you have experienced these before.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptom** | **New Symptom** | **Old Symptom but worse** | **Old Symptom but improved** | **Old Symptom but not changed** | **Symptom not present** |
| 1. Intrusive or unwanted thoughts | 1 | 2 | 3 | 4 | 5 |
| 1. Severe nervousness or anxiety | 1 | 2 | 3 | 4 | 5 |
| 1. Confusion or trouble concentrating | 1 | 2 | 3 | 4 | 5 |
| 1. Electric sensations in the brain, 'zaps' | 1 | 2 | 3 | 4 | 5 |
| 1. Feeling unreal or detached, depersonalisation, derealisation | 1 | 2 | 3 | 4 | 5 |
| 1. Agitation | 1 | 2 | 3 | 4 | 5 |
| 1. Brain fog, forgetfulness or problems with memory | 1 | 2 | 3 | 4 | 5 |
| 1. Trouble sleeping, Insomnia | 1 | 2 | 3 | 4 | 5 |
| 1. Sudden outbursts of anger (“anger attacks”), rage | 1 | 2 | 3 | 4 | 5 |
| 1. Bouts of crying or tearfulness | 1 | 2 | 3 | 4 | 5 |
| 1. Fatigue, tiredness | 1 | 2 | 3 | 4 | 5 |
| 1. Headache | 1 | 2 | 3 | 4 | 5 |
| 1. Racing thoughts | 1 | 2 | 3 | 4 | 5 |
| 1. Dizziness, light-headedness, or sensation of spinning (vertigo) | 1 | 2 | 3 | 4 | 5 |
| 1. Sudden panic or anxiety attacks | 1 | 2 | 3 | 4 | 5 |

1. If you have experienced any new symptoms that are not listed here, please describe below

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….